MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
BUREAU OF FAMILY AND COMMUNITY HEALTH
DIVISION FOR SPECIAL HEALTH NEEDS
250 WASHINGTON STREET, 4TH FLOOR
BOSTON, MA 02108-4619
1-800-882-1435
FINANCIAL ELIGIBILITY APPLICATION FORM
HEARING AID PROGRAM FOR INFANTS AND CHILDREN

INSTRUCTIONS: (Please read before completing application.)

The attached application form should be completed and signed by a parent, guardian, or the applicant (if financially independent). WRITTEN DOCUMENTATION OF INCOME MUST BE ENCLOSED. Once the completed forms and appropriate documentation are reviewed, you will be sent a letter indicating your financial eligibility determination. **The letter will serve only as your notice of eligibility for the program – it is not a hearing aid purchase authorization.** Final approvals can be made only after the program has received complete reports and recommendations directly from an audiologist at an approved evaluation center and a price quote from a participating hearing aid dispenser.

Please refer to the attached cover letter for more specific information about the program and review the current financial eligibility guidelines before completing this application.

Following is a list of definitions of certain terms used on this application form. If you need assistance or more information regarding the program, please consult your audiologist.

DEFINITIONS OF CERTAIN TERMS USED ON THIS APPLICATION:

APPLICANT: The child or young adult up to age 21 who will be using the hearing aid

FAMILY SIZE: The following people should be included in the determination of family size:

a. The applicant;
b. Each dependant of a parent or guardian of the applicant if the parent or guardian lives in the same household as the applicant and the applicant is less than 18 years of age;
c. If the applicant is 18 years of age or less, each parent or guardian of the applicant who lives in the same household with the applicant;
d. Each person of whom the applicant is a dependant;
e. If the applicant is married and lives in the same household with her or his spouse, the applicant's spouse.

DEPENDANT: A person who may legally be claimed as a dependant on the federal tax return of another person, (that is, someone who receives more than 50% of their support from that person).

INSTRUCTIONS CONTINUED ON THE NEXT PAGE:

ANNUAL GROSS INCOME: The sum of all before-tax income expected to be received during the twelve month period, which commences on the date of application.

1. Annual gross income includes, but is not limited to, the following:

    a. wages, salaries, tips, and commissions
    b. net earnings from self-employment, partnerships or business
    c. net rental income
    d. dividends
    e. interests
    f. annuities
    g. pensions
    h. royalties
    i. government benefits including, but not limited to, Department of Transitional Assistance, Social Security, Supplemental Security Income, Unemployment Compensation, Workmen's Compensation, and Veterans Administration
    j. alimony and child support payments received
    k. scholarships and fellowships not used for tuition

2. The following items are not counted in determining gross income:

    a. gifts and inheritances received
    b. withdrawals from bank accounts
    c. money borrowed
    d. capital gains from a one-time sale
    e. lump sum payments
    f. life insurance payment paid by reason of death of the insured
    g. scholarship and fellowships for tuition

VERIFICATION OF APPLICATION INFORMATION

1. The applicant shall provide some form of written documentation that indicates that the statements concerning income on the application form are correct. The preferred form of written documentation shall be the most recent federal tax form (including W-2's) of those persons whose income is counted in determining income. Written verification of income not included on federal tax forms must be submitted.
2. The applicant shall supply verification in the form of receipts or copies of billing statements for all medical bills (including dental) paid or incurred during the past twelve months.

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***PLEASE NOTE**: The application cannot be processed until all information and verifications are received.*

APPLICANT'S NAME: _____ _____
LAST FIRST

ADDRESS: _____

_____

TELEPHONE #: _____

MEMBERS OF FAMILY HOUSEHOLD: Specify relationship to applicant: Spouse, Father, Mother, Sister, Daughter, etc.

NAME	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	OCCUPATION	EMPLOYER'S NAME OR SOURCE OF INCOME
	APPLICANT			

ANNUAL GROSS INCOME: Include gross income of each parent or guardian if applicant is claimed as a dependant on their federal tax form. Include applicant's income if any. Include income from Social Security, Unemployment Compensation, etc.

APPLICANT: $_____
SPOUSE: $_____
FATHER: $_____
MOTHER: $_____
OTHER INCOME, PLEASE SPECIFY: $_____
ALIMONY OR SUPPORT RECEIVED: $_____

TOTAL GROSS INCOME: $_____

PLEASE ATTACH A COPY OF YOUR MOST RECENT FEDERAL INCOME TAX RETURN TO THIS APPLICATION.

HEALTH INSURANCE INFORMATION

Please provide the following information:

INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY #: _____

TELEPHONE #: _____

EFFECTIVE DATE OF POLICY: _____

NAME OF POLICYHOLDER: _____

HMO? YES _____ NO_____

NON HMO? YES _____ NO_____

DOES THE POLICY PROVIDE ANY BENEFITS TOWARD THE COST OF HEARING AIDS? YES _____ NO _____

IF YES, PLEASE EXPLAIN INFORMATION ON THE BENEFIT TOWARDS THE COST OF HEARING AIDS:_____

Is the applicant covered by MassHealth YES _____ NO _____

If yes, please provide the MassHealth #: _____

AUDIOLOGY CENTER/HEARING AID DISPENSER INFORMATION

Center where applicant received hearing aid evaluation:

NAME: _____

ADDRESS: _____

TELEPHONE #: _____

Hearing Aid Dealer or Hearing Aid Dispensing Center where you plan to obtain the hearing aid(s):

NAME: _____

ADDRESS: _____

TELEPHONE #: _____

Has this applicant received a hearing aid from the Department of Public Health in the past?

YES _____ NO _____

If yes, please provide the date that the hearing aid was received: _____

FAMILY HEALTH CARE

List medical bills (including dental) paid or incurred by the family during the past twelve months. (Do NOT list bills paid by health insurance, MassHealth (Medicaid), etc.) You may attach additional pages for information on medical expenses. Please attach documentation of such expenses.

DATES OF SERVICE: NAME OF PROVIDER: AMOUNT

ALIMONY OR CHILD SUPPORT PAYMENTS

Please list expected payments by applicant, applicant's parent/guardian or spouse during the next 12 months: **$**_____

LOSSES

The portion of any loss caused by fire, flood, other natural disaster, theft, or vandalism, which is in excess of $1,000 and is not recoverable through any insurance plan or policy.

REASON:

AMOUNT OF LOSS: $_____

COST OF HEALTH INSURANCE PREMIUMS FOR THE PAST TWELVE MONTHS

$_____

_____ _____

SIGNATURE OF APPLICANT OR PARENT/GUARDIAN **DATE**